Mrs M Holliday-Welch

Grosvenor Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Grosvenor Lodge is a residential care home providing personal care for up to 31 older people some of whom were living with dementia. There were 30 people living at the service during the inspection.

Grosvenor Lodge accommodates 31 people in one adapted building. There were three shared lounges, a dining room and accessible garden.

People's experience of using this service and what we found
Risks to people were not always appropriately recognised and assessed. Risks around people's health diagnoses, behaviour that may challenge and specific healthcare aids had not always been recognised and planned for. When people's behaviour could challenge, this was not always recorded and monitored appropriately. Safeguarding was not always reported appropriately when people displayed behaviour that challenged which affected other people.

People were not always supported to have maximum choice and control of their lives and staff did not support always them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

The quality assurance framework was not effective and had not supported the provider to identify and address the areas needing improvement. There was no guidance in place for medicines which were prescribed 'as required' (PRN). Staff were supported when they began administering medicines, and their competency to do this was checked, but this was not recorded.

People were treated with kindness, dignity and respect and encouraged to express their views and be involved in their care. One person told us, "It's my favourite place to come to." Another person's relative said, "I'm happy that she is safe and well looked after."

People's needs were assessed before they moved into the home. Care plans included people's life histories, hobbies and interests. When appropriate, people's preferences for the end of their lives had been discussed with them and their relatives.

There were enough staff available to meet people's needs. Staff were recruited using safe recruitment methods and supported with induction, training and regular supervision. Staff told us they felt supported by the management team.

People were supported to eat and drink, staff knew about anyone with specialist needs around food. People were supported to access health care support as needed. Staff worked in partnership with other agencies and professionals to support people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (9 March 2016)

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified three breaches of regulation in relation to the governance of the service. The provider failed to ensure that they had assessed, monitored and mitigated the risks relating to health, safety and welfare of people and others. The provider had not ensured that an accurate, complete and contemporaneous record in respect to each person had been kept.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Grosvenor Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Grosvenor Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and four health and social care professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care

provided. We spoke with seven members of staff including the provider, registered manager, deputy manager, senior care workers and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four peoples' care records, three staff recruitment files, records of accidents, incidents and complaints and other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks to people were not always recognised and assessed. For example, when people could display behaviours that challenged, this was not always appropriately reflected in their risk assessments and care plans. One person's care plan included that they could display inappropriate behaviours. When the person displayed behaviours that challenged staff told the person to stop. They did not identify what had caused the behaviour and did not demonstrate that they had tried to distract the person and did not put any measures in place to stop it from happening again. There was little detail in their care plan on how and when this may happen, any triggers to the behaviour, and how to keep them and other people safe. The lack of detailed guidance and detailed staff knowledge meant that staff did not have guidance to follow about how to manage these risks appropriately. Due to this not being managed well, there continued to be incidents of this behaviour.
● Risks around specific health diagnoses were not always individually assessed and planned for. For example, one person was living with diabetes. Their blood sugar levels were not within the usual levels. A risk assessment about the person's diabetes had been completed but was not tailored to the person and how they would present when they were well or unwell. When we spoke to staff about this, they could not consistently tell us about the person's blood sugars and how to support them.
● Risks about specific aids had not always been appropriately planned for. For example, one person had a stoma. A stoma is a surgical opening on the surface of the stomach in order to manage a person's elimination needs. There was no guidance available to staff about how to support the person with this. Staff told us that the person could take their bag off on occasion, meaning there was an increased risk of infection at the stoma site. The person's keyworker knew the person, and how to care for their stoma well, including checking the site with the person regularly throughout the day. However, these risks had not been assessed, recorded and planned for and the knowledge had not been shared with other staff. Therefore, there was a potential risk of the person receiving unsafe care.

The provider had not ensured that people received safe care and treatment. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks about people moving around were considered. People's ability to move themselves was assessed and any aids needed were considered. Staff had training in the manual handling of people. A member of staff said, "I found that useful, showing us how to get sling off when someone is in a chair and changing their

position."
● Risks about people's skin were considered. When people were at risk of their skin developing pressure sores this was assessed. Topical barrier creams and pressure relieving mattresses and cushions were used to reduce the risk. Community nurses were involved as required.
● Regular checks were in place to ensure a safe environment, this included checks on electrical equipment such as the lift.
● Plans were in place in the event of an emergency. People had personal emergency evacuation plans which detailed the support they would need to evacuate the building. Fire detection and fighting equipment was regularly checked.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Referrals to the local authority about safeguarding had not always been made when needed. For example, one person was behaving in a way that affected other people living in the home. In the two weeks ahead of the inspection there had been five incidents involving this person. The registered manager had not recognised that this was a potential safeguarding concern. When this was discussed with the registered manager they made a referral to the local authority immediately.
● Staff understood how to respond in the event of a person falling. One member of staff said, "If they fall and knock their head I'd call the paramedics. Otherwise I see how they are, help them up if they are able to walk, check they are not in pain. I note it all down in the book and forms and communication book, so all staff are aware of it. Occasionally the falls prevention team will come in, if someone is falling regularly." The registered manager explained that one person had been placing themselves on the floor. Staff had referred to specialist professionals to support this person.
● Staff we spoke to understood safeguarding and how to recognise signs and types of abuse. Staff told us they would raise any concerns with the registered manager or provider.

Staffing and recruitment

● There were enough staff available to meet people's needs. Call bells were answered quickly, and staff were able to spend time with people. Rotas showed that there were sufficient staff planned for each shift. One person's relative told us, "Staff are lovely, doesn't matter what time you come in. They look after us as well. They are patient and kind."
● Safe recruitment practices were followed which included references from previous employers, proof of identity and checks through the Disclosure and Barring Service (DBS). DBS checks help employers to make robust decision about staff they recruit.

Using medicines safely

● There was no guidance, such as protocols, in place when people were prescribed medicines 'as required' (PRN) for pain relief or anxiety relief. PRN protocols support staff to know when to give these medicines. Staff knew how people would present with agitation or anxiety, but this was not documented. We considered this to have a low impact to people as staff giving people their medicines knew people well. However, there was a potential risk that if staff who did not know people so well were to give people their medicines, they would not have sufficient guidance available to do so safely. When we raised this with the registered manager they agreed to put in place this guidance.
● Staff had training in how to support people with medicines. Once this was completed the registered manager would check their practice to be assured of their competency to give medicines safely. Medicines were stored safely, with the temperature of the room checked regularly. There were good processes for

ordering and returning medicines with the local pharmacy.
● Staff gave people their medicines safely. We saw staff offer people their medicines in their preferred way. Staff understood what to do if a person refused their medicines. One member of staff said, "I try again in a bit, ask another staff member to offer the medicines. If they won't take then, I note it as a refusal. If it carries on, we'll chat to the GP to review."

Preventing and controlling infection

● Infection control was well managed. Staff used personal protective equipment, such as gloves and aprons, as needed.
● Staff had training in health and safety and infection control and the home was clean and tidy. One person's relative said, "There is always somebody cleaning." Another told us, "The cleanliness is second to none."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Although staff had training about MCA staff were not following the principles of the MCA. Restrictive practices had not always been recognised, appropriately assessed and agreed. For example, one person who could display behaviours that challenged, had been asked or told by staff to go to their room. This had not been considered by staff as seclusion and a restrictive practice. The registered manager advised the person may lack capacity but support with capacity was not assessed as part of good care planning. . However, the person had not been supported to be involved in deciding the best support and the behaviours continued. Other, more proactive ways had not been considered or trialled. The behaviours and seclusion continued without assessment, agreement or review.
- Staff had made best interest decisions on behalf of people. For example, decisions about the texture of their meals, the management of health conditions and smoking cigarettes. They had not involved people or their representatives in the process, communicated with them in an appropriate way, or used people's responses to inform an assessment of whether they were able to make a decision.

The provider had not ensured that they were following the principles of the Mental Capacity Act. This was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- . We saw staff offering people choices, such as meals, drinks and what they wanted to do and encouraging

them to make decisions throughout the day.
● Conditions on authorised DoLS were being met. For example, for one person the condition was for staff to support them to practice their faith. Staff had taken action to meet this condition.
● Records were kept about people's DoLS, and conditions and when the authorisations were due to expire. A member of the local authority DoLS team told us, "My experience is that Grosvenor Lodge show a good understanding of DoLS and make appropriate referrals to our service in a timely way."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they moved into the home. Assessments included people's needs, personal background and religious beliefs. One person's relative told us, "They did their own assessment and talked to us about (our relative). There were sheets for us to pass on any information we could for her."
● Specialist assessment tools were used to assess people's risks. For example, the Malnutrition Universal Screening Tool (MUST) was used to score people's risks of malnutrition.

Staff support: induction, training, skills and experience

● Staff new to the service were supported with an induction. This included training and shadowing more experienced staff to learn from them and get to know the people living at the home. Staff new to the service told us the induction program was enough to make them feel confident.
●Staff new to the care sector were supported to undertake the care certificate. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
● Staff were supported with training and supervision. Training included support with diabetes, fire, first aid and dementia awareness. One member of staff told us, "The dementia training was quite eye opening. It's good to understand why they [people living with dementia] are them, why they talk in that way or their attitude to things might be that way."

Supporting people to eat and drink enough to maintain a balanced diet

● People received support to eat and drink safely and enjoyed the food. One person told us, "The food is good here." Another person's relative said, "The food is excellent." Staff knew about people who had health conditions, such as diabetes, which affected their diet.
● People were offered choices about their meals. Pictorial communication cards were used to help people understand their choices, when relevant. If people did not want their meals when they were served, an alternative was offered.
● Some people needed to have their food at a soft consistency. This was known and understood by staff working in the kitchen. When people needed staff support to eat their meals, this was provided. Staff sat with people and engaged them in conversation whilst providing this support.
● We observed a meal time. The tables were laid with tablecloths and placemats. Some people chatted whilst they ate. Staff spoke to people about the meal and encouraged them to eat. One person chose to leave the dining room before dessert was serviced. Staff spoke to them and offered them dessert, but they declined.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were supported to live healthier lives. Records showed that people saw health professionals

regularly, including GPs, community nurses and specialist mental health professionals. People's relatives told us they were kept informed. One person's relative said, "If [my relative] is poorly, they always tell me what is happening."

● A health and social care professional told us, "I have seen that residents receive the required referrals to health professionals, may this be physical or mental health issues and that they appropriately review treatment and symptom control."

● A visiting health care professional said, "The staff take on board any advice we give and follow care plans. They are quick to alert us to any problems or issues that occur with their residents."

Adapting service, design, decoration to meet people's needs

● The home had been decorated to meet the needs of people living with dementia. For example, corridors on different levels of the home were different colours, to help people recognise the route to their bedrooms. Doors to people's bedrooms were decorated in the style of a front door and personalised with people's names and photographs to help people find their way around.

● The communal garden included places for people to sit and socialise. There was a rabbit hutch and run and people and staff told us about how they enjoyed spending time with the rabbits.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People were treated with kindness, care and compassion. One person told us, "The atmosphere is good, and the staff are good." One person's relative said, "Nothing is ever too much trouble." Another person's relative told us, "I'm thrilled that we found this place. They are fab here, I have no doubts or qualms. They are so caring. There couldn't be anything better than what she is getting."
● Staff spoke kindly to people. For example, one person appeared distressed and was picking at the wall. A member of staff noticed and engaged the person in conversation. They then supported the person to take part in an activity instead. Another person's relative told us, "If she is having a bad day, they will try and bring her out of it."
● Staff enjoyed supporting people. One member of staff told us they enjoyed, "Helping people live their lives really, day to day." Another said, "I like helping each individual have the best quality of life they can possibly have."
● People's relatives told us they were welcome to visit when they wished. One relative told us, "I am welcomed, and always offered tea and biscuits."

Supporting people to express their views and be involved in making decisions about their care

●People's views were sought about their care. For example, a member of staff told us about a person who had recently become frustrated with them when they offered them support with personal care. The member of staff said they swapped with a colleague, who the person was happy to accept support from.
● People's individual views on the service provided were sought regularly through resident's meetings. Staff asked people if they felt happy, safe and other questions about their experience at the home.
● When people's relatives were involved in their care, they were kept updated. One person's relative told us, "They've always consulted with us about anything that was going on and discussed with us. If the nurse or doctor has been around, I get updates on that."

Respecting and promoting people's privacy, dignity and independence

● People's privacy was respected. Staff knocked on people's doors before entering and protected people's privacy whilst providing personal care.

● People were treated with dignity. Staff used people's preferred names and knew their preferences. One person's relative said, "They treat her with dignity and respect." A visiting health care professional said, "Residents seem well supported and treated respectfully and seem content to be there."

● People's independence was promoted. One member of staff told us, "I talk people through every step of the way and try and get them to help themselves. It can be quite horrible if everything is done for you. I get them to lift their legs and do what they can to be involved."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People received personalised care. Staff knew people and their needs well, and how to support them safely. A health and social care professional told us, "The residents have keyworkers which I feel enables the staff team to develop a better understanding of the individual's history and current care and support needs, building relationship and ensuring the needs of the individual are documented, care planned and achieved."
● People's care plans included their life stories, what their childhood was like, where they had worked, their families and interests. The deputy manager explained, "I get to know people and what they want and what they like. In terms of getting them involved, it's working out their likes and dislikes and preferences over time and more about us getting to know them."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers'.
● People's communication needs were considered as part of their assessments and care plans. There were pictorial boards displaying activities on offer at the home. Staff had a visual communication aid book, containing pictures to support people's understanding, which helped with communicating with people who required a visual prompt. We saw staff use pictures to help people make choices about their lunchtime meal.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to continue to follow their interests. For example, one person's care plan told us how important having their daily newspaper was to them. We saw the person with their paper and they told us they had it delivered daily.
● We saw people and staff singing and chatting together throughout the inspection. People and staff spoke together about local Brighton and Hove landmarks and their history. The member of staff then led people to

sing a song about the seaside together.
● People's relatives told us there were always activities on offer. One person's relative said, "Like for Easter. They do bend over backwards. They had live chicks coming out of the shells, people are allowed to handle them and stroke them, same as the rabbits."
●People were supported to maintain their religious and spiritual beliefs. For example, one person was regularly visited by their priest.
● Staff told us that people went out in the community occasionally. One member of staff said, "One lady likes to go out in her wheelchair, but that is weather dependent."

Improving care quality in response to complaints or concerns

● Complaints had been listened and responded to. For example, there had been concerns raised about the placement of furniture. The registered manager had spoken with the people involved and discussed how to resolve the issue.
● People and their relatives told us they could raise any concerns if they needed to. One person told us, "We soon tell them if we don't like it." Another person's relative said, "They've always made themselves available, I've just never needed to." Another said, "They do their best to put right what we're anxious about."

End of life care and support

● People received tailored support at the end of their lives. One person was receiving end of life care at the time of the inspection. Staff were working with the person's GP to ensure they remained comfortable. They had been prescribed end of life medicines, so they could have a pain free death and had a care plan in place about end of life care.
● When people had wishes around the end of their lives, for example about resuscitation, this was known by staff and relevant documents were kept accessible. People's relatives, when appropriate, had been involved with planning for people's future wishes. For example, where people would prefer to be cared for at the end of their lives and whether they had any religious or spiritual beliefs that would be important to them at this time.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

●The quality assurance framework had not identified and addressed all areas for improvement identified during the inspection. For example, monthly medicine audits were completed, which included a question on whether there were PRN protocols in place. However, this had not resulted in the completion of PRN protocols. Processes were in place to ensure staff's competency to give people their medicines, but this was not recorded.
● Risks to people through their health and behaviour had not always been appropriately assessed and recorded. The quality assurance framework had not identified and rectified these concerns.
● When things went wrong, for example with behaviour that could challenge, the records kept about the incident were not always detailed. This made looking for patterns and taking appropriate action to support the person more difficult.

● When people's capacity to make decisions was in doubt, this had not been appropriately assessed, recorded and support in line with the Mental Capacity Act. The lack of accurate and contemporaneous records could leave people at risk of receiving support which was inappropriate or inconsistent.

The provider had not ensured that the quality assurance system was sufficiently robust to identify the shortfalls we found in relation to records. This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

● A falls audit was completed monthly, this helped the registered manager to identify any themes or trends and ensure appropriate action had been taken. For example, they had requested a placement review for one person, so they could work with the local authority to meet the person's needs.
●Staff felt supported by their colleagues and the management team. One member of staff told us, "I enjoy and look forward to coming to work."
● Staff meetings were held. One member of staff told us, "If there are any issues, we share our views. If there is anything we've found difficult, we share our ideas about that." Minutes of the meetings showed discussions about people, the planned renovation and activities.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Although we identified a series of incidents regarding one person that had not been reported appropriately, other incidents had been appropriately reported to the local authority and CQC.
● The registered manager reflected on their responsibilities under duty of candour following our feedback.
● People's relatives had been contacted when things went wrong. One person's relative told us, "They involve us, when she had a fall they called, and took her to hospital."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff felt supported and there was an open door policy by the registered manager for any issues, for staff, people and relatives. One person's relative said, "It's run really well."
●There were systems in place to reward staff. For example, an employee of the month was rewarded with a voucher. Staff told us they enjoyed working at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, relatives, staff and professional's views of the service provided were surveyed. The registered manager was in the process of collecting the responses, but those seen were positive.
● People living at the home had regular meetings together. Discussions included what they would do to celebrate occasions like Easter, menus, activities and checking whether anyone had any complaints.

Working in partnership with others

● Staff worked in partnership with other agencies such as the community nurses, local authority and falls prevention team. A health and social professional told us, "I have continued to work with some residents on a few occasions. I have witnessed the support that the residents have received from the staff team, and how the staff adapt the support to the individual, exploring all avenues to address their needs in the best way and to continue to encourage their independence, as much as possible. They are willing to try varying ways to support them in difficult circumstances."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's capacity to make particular decisions had been appropriately assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that they had assessed, monitored and mitigated the risks relating to health, safety and welfare of people and others. The provider had not ensured that an accurate, complete and contemporaneous record in respect to each person had been kept.